Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932662	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA SHORES ASSISTED LIVING	1229 MANGO TREE DRIVE EDGEWATER, FL 32132

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey, CCR # 2013001618 was conducted at Florida Shores Assisted living Facility in Edgewater, Florida on , 2013. Licensure deficiencies were identified at the time of the survey.	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met in an assisted living facility; and 8. The date of the examination, and the name, signature, address, phone number, and license	A 008		

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A 008	Continued From page 1	A 008		

number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.
b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.
c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.
2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the

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A 008	Continued From page 2 elements in Section 3. This requirement does not apply for residents receiving: a. Extended congregate care (ECC) services in facilities holding an ECC license; b. Services under community living support plans in facilities holding limited mental health licenses; c. Medicaid assistive care services; and d. Medicaid waiver services. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823. (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a [illegible] order for residents who do not wish [illegible] to be administered in the case of [illegible] or (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or	A 008		

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A 008	Continued From page 3 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and staff interview, it was revealed facility failed to ensure resident health assessments were complete with signatures and required entries for 2 of 7 sampled residents. (Residents #1 and #4) The findings include: On ..... during resident #1's and #4's record reviews it was revealed residents' health assessments did not have the required entries on page 5, indicating what services the facility was providing to both residents, and signatures of the administrator, along with the date. Page 2 - which indicated the level of function with activities of daily living, diet orders, and conditions which would make the resident inappropriate for assisted living placement was missing altogether for Resident #1. On ..... at approximately 12:10 pm in an interview with the facility's administrator, he	A 008		

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A 008	Continued From page 4 acknowledged resident 's health assessments had missing signatures, pages and entries. Class III	A 008		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

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A 025	Continued From page 5 This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide appropriate care and services by not notifying a resident's physician and family of a fall with injury resulting in a significant change in condition for one of seven residents (Resident # 1). The findings include: On [redacted] at approximately 12:10 pm in an interview with the facility's administrator, he stated on [redacted] Resident # 1 had gotten up out of her bed and was walking around in her [redacted] and hit her forehead on the edge of a table in her [redacted] sustained a [redacted] to her forehead. He stated he assessed the resident and applied ice to her injury and saw no broken skin. He stated on [redacted] he tried to make contact by phone with her daughter to inform her of her mother's fall incident; but did not get an answer or a return phone call from her, nor did he make repeated attempts to notify her daughter. He stated he did not think at the time the incident occurred, resident # 1 needed medical services. The resident's physician was not notified of the resident's [redacted] He stated he assessed her and she only had [redacted] and no broken skin, so he did not transport her to the physician at the time of the incident. A review of the resident's medical record revealed that staff had documented their attempt to notify the daughter of the fall on [redacted] The note, dated [redacted] read "Resident got up on her bed and walk around inside the [redacted] She fell down; she hit her forehead on the edge of the table.	A 025		

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A 025	Continued From page 6 Resident got a big bump on her left forehaed. We put pressure and ice on it. Check everything. No open skin/wound. [illegible] daughter - name of daughter." A review of the resident's health assessment, AHCA Form 1823, dated [illegible] that the physician had indicated that Resident #1 needed fall [illegible] Page 2 of the health assessment was missing in the resident's record, which would have indicated if the resident needed assistance with transfers and ambulation. Interview with the administrator on 2/1[illegible] 12:10 pm revealed that he had sent portions of Resident #1's record to the medical examiner's office without making copies. Further interview with the administrator on 2/1[illegible] 12:15 pm revealed that the resident's doctor came to the facility on 6/1[illegible] visit her for a routine check-up and assessed her and informed him she needed to go to the hospital for evaluation. He stated on 6/1[illegible] transported resident to a local hospital and she was admitted to the hospital for a injury to her forehead, 3 days after the resident fell. [illegible] review of Resident #1's Emergency Department Report, dated 6/1[illegible] that the caregiver, (the facility administrator) had informed the physician that Resident #1 had "progressively decreasing level of functioning, decreased frequency of ambulation with walker, apparent generalized weakness. [illegible] fell [illegible] week at ALF trying to get out of bed, sustained contusion [illegible] forehead. No LOC (loss of consciousness). [illegible] change in baseline dementia [illegible] caregiver. Today caregiver took patient to PCP (primary care physician) who sent patient to ED (Emergency Department) for evaluation and	A 025		

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A 025	Continued From page 7 hospitalization." Class II	A 025		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida [illegible] Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of	A 030		

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A 030	Continued From page 8 its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s ..... and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical ..... shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical	A 030		

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A 030	Continued From page 9 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a his or her spouse if both	A 030		

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A 030	Continued From page 10	A 030		

are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

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A 030	Continued From page 11	A 030		

This Statute or Rule is not met as evidenced by:
Based on record reviews and staff interviews, facility failed to provide one of seven residents (#1) access to adequate and appropriate health care after a fall wherein the resident sustained injuries and required medical treatment for 1 of 7 sampled residents. (Resident # 1)

The findings include:

On [redacted] at approximately 12:10 pm in an interview with the facility's administrator, he stated on [redacted] Resident # 1 had gotten up out of her bed and was walking around in her [redacted] and hit her forehead on the edge of a table in her [redacted] sustained a [redacted] to her forehead. He stated he assessed the resident and applied ice to her injury and saw no broken skin. He stated on [redacted] he tried to make contact by phone with her daughter to inform her of her mother's fall incident; but did not get an answer or a return phone call from her, nor did he make repeated attempts to notify her daughter. He stated he did not think at the time the incident occurred, resident # 1 needed medical services. The resident's physician was not notified of the resident's [redacted] He stated he assessed her and she only had [redacted] and no broken skin, so he did not transport her to the physician at the time of the incident.

A review of the resident's health assessment, AHCA Form 1823, dated [redacted], revealed that the physician had indicated that Resident #1 needed [redacted] precautions. Page 2 of the health

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A 030	Continued From page 12 assessment was missing in the resident's record, which would have indicated if the resident needed assistance with transfers and ambulation. Interview with the administrator on ... at 12:10 pm revealed that he had sent portions of Resident #1's record to the medical examiner's office without making copies. Further interview with the administrator on at 12:15 pm revealed that the resident's doctor came to the facility on to visit her for a routine check-up and assessed her and informed him she needed to go to the hospital for evaluation. He stated on he transported resident to a local hospital and she was admitted to the hospital for a injury to her forehead, 3 days after the resident ... A review of Resident #1's Emergency Department Report, dated revealed that the caregiver, (the facility administrator) had informed the physician that Resident #1 had "progressively decreasing level of functioning, decreased frequency of ambulation with walker, apparent generalized ... Patient ... last week at ALF trying to get out of bed, sustained left forehead. No LOC (loss of No change in baseline ... per caregiver. Today caregiver took patient to PCP (primary care physician) who sent patient to ED (Emergency Department) for evaluation and hospitalization." Class II	A 030		
A 162	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include:	A 162		

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A 162	Continued From page 13 (a) Resident demographic data as follows: 1. Name; 2. 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance 8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and 9. Name, address, and phone number of health care provider, and case manager if applicable. (b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C. (c) Any health care provider ' s orders for medications, nursing services, therapeutic diets, or other services to be provided. supervised, or implemented by the facility that require a health care provider ' s order. (d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C. (e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A weight record which is initiated on admission. Information may be taken from the resident ' s health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually. (g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident ' s contract.	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932662	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA SHORES ASSISTED LIVING	1229 MANGO TREE DRIVE EDGEWATER, FL 32132

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A 162	Continued From page 14 (h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident ' s contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S. (k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S. (l) A copy of Alternate Care Certification for Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services. (m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C. (o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their	A 162		

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FLORIDA SHORES ASSISTED LIVING	1229 MANGO TREE DRIVE EDGEWATER, FL 32132

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A 162	Continued From page 15 homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required under this subsection; 3. The medical examination described in Rule 58A-5.0181, F.A.C.; 4. The resident ' s contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider ' s order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility. (q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review, and staff interviews, the facility failed to maintain complete resident record files with required documents for 1 of 7 sampled residents for the required 2 year period after discharge of resident. (Resident # 1)	A 162		

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A 162	Continued From page 16 The findings include: On [redacted] record review of resident # 1's record revealed resident file was missing numerous documents. Parts of resident # 1's contract, admission package, medication records, facility notes, health physician notes, ER visits, and hospital admissions were missing from her file. On [redacted] at approximately 12:10 pm in an interview with the facility's administrator, he stated documents were previously in resident's file. He stated he received a certified letter from the county's medical examiner's office requesting resident # 1's health files. He stated he sent the medical examiner's office his original copies and the office had not returned the files to him. Class III	A 162		
A 165	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is	A 165		

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FLORIDA SHORES ASSISTED LIVING	1229 MANGO TREE DRIVE EDGEWATER, FL 32132

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A 165	Continued From page 17	A 165		

required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means:
(a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in:
1.
2. or spinal damage;
3. Permanent
4. or of bones or joints;
5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;
6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident.
(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident.
(6) , neglect, or must be reported to the Department of Children and Family Services as required under chapter 415.

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A 165	Continued From page 18 (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial	A 165		

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A 165	Continued From page 19 Adverse Incident Report-1 Day, 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form 3180-1025, Assisted Living Facility Full Adverse Incident Report-15 Day, dated 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to file the required adverse incident report with the agency for one of seven residents who and sustained an injury which required transfer to an acute care setting. The findings include: On during facility record reviews, it was	A 165		

Agency for Health Care Administration

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A 165	Continued From page 20 revealed facility failed to submit required adverse incident reports for [illegible] incident that occurred with resident # 1 on [illegible]. On [illegible] at approximately 12:10 pm in an interview with the facility's administrator, he acknowledged when resident #1 [illegible] on [illegible] and sustained injuries and had to be transported to the hospital on [illegible], he did not file required adverse incident report with the agency. Class III	A 165		

..... 14, 2013

Florida Shores Assisted Living
C/O Isabelo Nudalo, Jr., Administrator
1229 Mango Tree Drive
Edgewater, Florida 32132

Dear Mr. Nudalo,

This letter reports finding of a complaint survey, CCR# 2013001618, conducted by a representative of the Agency for Health Care Administration on , 2013. Attached is the provider's copy of the State (3020) Form, which indicates there were deficiencies noted during the investigation.

You are directed to provide a plan of correction to the Jacksonville Field Office for the identified deficiencies within **ten calendar days** of receipt of this faxed report. The plan should be directed to the attention of Mr. Rob Dickson, Field Office Manager and mailed to:

Agency for Health Care Administration
Health Quality Assurance, Jacksonville Field Office
921 North Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone: (904) 798-4513
Fax: (904) 359-6054

The investigation resulted in findings of noncompliance with the following areas:

1. A 8 – Health Admissions – Class III
Your assisted living failed to ensure that the administrator completed health assessments with the services the facility would be providing residents in accordance with the needs identified by the primary care physician. This non-compliance could potentially affect the well-being and safety of the residents living in the facility.

2. A 25 Supervision – Class II
Your assisted living facility failed to ensure that staff provided appropriate care and services to a resident by failing to notify a physician and family of a resident's significant change in condition. This noncompliance possesses a direct threat to the health and welfare of residents living in your facility.

3. A 30 Resident Rights – Class II
Your assisted living facility was found to have a violation of a resident's right to access to adequate and appropriate health care. This noncompliance possesses a direct threat to the health and welfare of residents living in your facility.

4. A 162 – Class III
Your assisted living facility was found to have a violation of failure to maintain complete resident records. This non-compliance could potentially affect the well-being and safety of the residents living in the facility.

5. A 165 – Class III
Your assisted living facility was found to have a violation of failure to file required adverse incident reports. This non-compliance could potentially affect the well-being and safety of the residents living in the facility.

Your plan of correction must include the following:

1. A description of how you will ensure that all sections of the health assessment will be completed by the physician, the administrator and/or designee

2. A description of how you plan to address the assessment of a resident by licensed medical professionals (registered nurse or physician) after they sustain an injury; development of a written policy of timeframes of successful notification to primary care physician, the resident's responsible parties, and subsequent transfer to an acute care setting, if deemed necessary by licensed staff; and the provision of in-service education to all staff regarding procedures for emergency medical care after residents sustain injuries.

3. A description of how you will ensure that resident records have all required documentation

4. A description of how you will investigate incidents of resident injuries in order to determine if the incident is adverse, along with a timeframe for reporting adverse incidents to the Agency

Should you have any questions, please call ..... Keisha Woods, Health Facility Evaluator Supervisor, at 904-798-4516.

Regards,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance